Approaches to Children, Young People and Mental Health: Confusion in the Ranks, Confusion Among the Commanders

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The need to provide support for the mental health needs of children and young people is not in dispute. However, there does exist confusion as to the most appropriate means and methods of providing such support. This confusion is particularly evident among those who work closely in providing daily for the mental health needs of children and young people, yet who lack specific mental health training. The confusion is heightened by the fact that those who have developed expertise in mental health cannot offer a consensual approach. This article discusses this confusion and its implications for other sectors by considering some of the theoretical and practical debates in the psychological literature concerning the most effective approaches to mental health interventions. Some commonsense recommendations from this literature for those working with children are offered.

Mental health problems in children and young people in Australia are a growing concern among mental health and welfare professionals, parents, teachers and government agencies. A large national survey carried out by the Australian Institute of Health and Welfare in 2001 (AIHW, 2003) found that suicide deaths among young people were 10.1 per 100 000 with the proportion being 4–5 times higher in males than females. However, females were twice as likely to be hospitalised for self-harm than males (AIHW, 2003). Nine per cent of all hospitalisations for young people were for mental disorders, with depression, schizophrenia, severe stress reactions and eating disorders being the leading causes of hospitalisation. Risky alcohol use among adolescents was high. Among children, a similar large scale study (Al-Yarman, Bryant, & Sargeant, 2002) found that 15% of boys and 14.4% of girls aged 4–12 years have a number of emotional and/or behavioral problems. In particular, in children aged 6–12 years, there was evidence of more serious problems such as the finding that 19.3% of boys and 8.8% of girls were reported to have

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attention-deficit/hyperactivity disorder. Twenty-nine per cent of boys and 23% of girls aged 12–15 years reported having taken an illicit drug at least once. On the basis of such figures there is reason to be concerned and to place pressure on governments to provide services to support the alleviation of such mental health problems among children and young people.

However, while acknowledging a likely problem, there is also a feeling among many that the picture is not so clear and, in particular, not as gloomy as it appears on first reading. Even from such a large study of young people's mental health as that carried out by the AIHW other figures suggest a different perspective. Less than 3% of males and 6% of females were found to have high levels of psychological distress. Eighty per cent of young people rated their lives as mostly satisfactory to delighted, while only 4% rated their lives as unsatisfactory to terrible. Those who had not completed their schooling or were unemployed were more inclined to have negative opinions about their lives and their health, respectively. This unclear picture often makes it difficult for many of those working with children and young people on a broader basis, such as in schools, to decide on the approach to be taken in the areas of prevention, promotion and services for mental health. Many are beginning to ask questions that may have been avoided in the past for fear of being labelled 'uncaring' or 'politically incorrect'. Yet many still held the nagging doubt of whether or not we may be distorting our view of children and young people by focusing attention on a minority of quite disturbed individuals who may be overrepresented in the figures of maladjustment and mental disorder. In so doing, many question if we have begun to pathologise what may simply constitute the normal 'ups and downs' of life. Are we relegating this younger generation to a mistaken belief that you should always 'feel good' and that to feel any distress at all indicates a mental disorder in need of treatment? Are we depriving them of an understanding that life is composed of good and bad, light and dark, and that in experiencing both, they can become resilient in the face of whatever may present itself in life? Or alternatively, are the figures of diagnosed mental disorder in fact only the tip of an iceberg of distress that largely goes unreported among our children and young people? Depending on the reality of the situation, approaches to mental health among children and young people would be very different in each scenario.

This dilemma for the general community in deciding the best way to care about the distress of our children and young people has been complicated by confusion within the academic mental health literature, where professionals are forced into the defence of their particular theory or practice, thus clouding informed decision-making and reducing the likelihood of innovative change. This article seeks to explore some of these controversies and considers their implications for the care of the mental health of children and young people.

Models of Mental Health

The issue of the models adopted to consider health and ill health, and hence mental health versus mental illness, have contributed to confusion in the offering of care. Wampold (2001) argues that in terms of considering levels of abstraction in approaches to mental health and psychotherapy, there are two broad metatheories

that encompass other theoretical approaches and techniques: the medical model and the contextual model. The medical model considers mental disorder in terms of illness, it being an absence of mental health. As in physical illness, such illness then is to be diagnosed and treated using the most effective processes.

This medical model has been, and remains in western society, the predominant model in determining mental disorder among children and young people. Within such a model, assessment and accurate diagnosis according to set criteria become paramount. Classificatory systems such as those provided by the DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders* [4th ed. text rev.]; APA, 2000) and the ICD-10 (*International Statistical Classification of Diseases and Related Health Problems 10th revision*, 1994) have been developed to group symptoms of conditions, including mental disorder among the young, and provide consistency of diagnosis across settings. Meyer (2003) argues that such classificatory systems are based on the deviance (or bizarreness) of behaviour from the norms of that society; the continuity and/or persistence of disordered behaviour over time, and the resulting degree of disruption in intrapersonal and/or interpersonal functioning. The use of classificatory systems in mental health has been valuable in increasing diagnostic agreement between clinicians; improving reporting on morbidity, services, treatment and outcomes; enhancing research to improve knowledge of disorders and treatment; and improving communication with those facing a disorder, carers, the public and other disciplines.

However, there are also problems in the use of classification of mental disorder. For example, labelling of a mental disorder has clouded the care of people in other areas of their lives that contribute to their wellbeing, while stigma associated with the diagnosis of mental health problems has led to people being ostracised. In children and young people, strengths of the child in other areas have often been overlooked in favour of a concentration on alleviation or control of the diagnosed disorder and associated deficits (Maxmen & Ward, 1995). Some argue that a diagnosis actually brings about a self-fulfilling prophesy (Madon, Jussim, & Eccles, 1997), where for example, the behaviour of a child labelled 'conduct disordered' in his or her records may be constantly considered problematic by each new teacher or carer, even when their behaviour falls within the realms of normal behaviour for that child's developmental age (de Monchy, Pill, & Zandberg, 2004). As a result, the child internalises that label and adjusts his or her behaviour to meet that expectation.

Many people's mental health symptoms lie in the 'grey area' of diagnosis between normal and extreme, and often symptoms are vague or subtle and culture-bound. They exist on a continuum where appropriate cut-offs defining disorder are debatable and likely to be different for different individuals (Maxmen & Ward, 1995). In addition, the fact that diagnosis is determined on the basis of sets of connected symptoms agreed on by a panel of experts, rather than objective measures such as blood tests available in some other physical conditions, problems of individual interpretation, misdiagnosis and differential diagnosis can affect the short- and long-term care of an individual child or young person (Jablensky, 1999). Some symptoms may in fact simply be a variation of normal and be developmental in nature (Maxmen & Ward, 1995). In addition, the interview with a person is the primary source of data in determining mental disorder. As such, a certain trust and ability to communicate symptoms may need to be developed with the person before there is

full and accurate disclosure that would contribute to accurate diagnosis. Such communication with children and adolescents is often difficult in time-limited and resource-deficient situations, particularly among children who live in quite chaotic life circumstances (Geldard & Geldard, 2002). Consequently, disorders among children may be diagnosed on the basis of reports from significant adults, reports that may be affected by bias, misunderstanding, misinterpretation, the reporter's agenda for presenting the child, or mental disorder of the reporting adult him- or herself (Vernon, 2004).

A medical model–driven approach to mental health as the alleviation of illness has also led to an emphasis on evidence-based practice as determined by strict hierarchies of evidence that favour particular scientific forms of enquiry, the determination of best practice guidelines in psychiatric services largely within formal service settings, and the determining of measurable outcomes across limited time periods. In addition, the medical model has introduced the idea of prevention of illness that has led to the search for risk and protective factors with resulting screening measures and early diagnosis programs. Such programs in schools have sought to screen children and young people for risk, and target resources toward the prevention of further deterioration. However, screening has at times failed to identify those most at risk. For example, depression has been identified as an important risk factor for youth suicide and therefore has been rightly targeted for early intervention. However, while this has identified many young people at risk, many are still missed. Girls, for example, are more likely to report clinically significant levels of depression; however, rates of completed suicide are much higher among young males (Sawyer et al., 2000).

The medical model has often been characterised as a deficit model, concentrating on problems within the individual child or young person. A further expansion of the model to the biopsychosocial model of illness increased the recognition of the interaction of physical causes of illness with psychological and social factors (Caltiabiano & Sarafino, 2003). However, the emphasis remains on the diagnosis and alleviation of individual deficit.

A contextual model of mental health care considers the vital recognition of the individual in the context of family, community and society. Such an approach recognises the potential influence of factors external to the individual as contributing to the development of mental health problems. As such, intervention for the same diagnosable condition may differ depending on the objective data, individual perceptions of the experience and the needs of the particular person. Therefore a broad set of options for intervention may be offered. A contextual model has also encouraged a health promotion approach to mental health that has emphasised modification of health determinants to reduce mental disorder, population-based approaches with greater emphasis on community resources and capacity-building, and the involvement of multisectors and multidisciplines in varied settings.

The Importance of the Individual and Alliance

In addition to recognition of a need to consider the context of the whole child or young person rather than just identify and treat deficits within the individual is the emergence of new areas and debates within psychological study. The objective

assessment of symptomatology of disorder leading to specific treatments has been challenged by the recognition that the experience of any situation including mental disorder is uniquely constructed by each individual. Largely championed within the area of Personal Construct Theory (Kelly, 1955; Neimeyer & Mahoney, 1995) is the concept that no matter the objective facts surrounding a situation, every individual will construct that event differently according to an internal schema through which he or she interprets life experiences. For example, one adolescent whose family has a history of major depressive disorder may view his or her mental distress as normal and even to be anticipated. This may lead to a greater acceptance of the condition or, alternatively, may make him or her more fearful of a negative future as has been experienced by other relatives. As a result, intervening successfully with children and young people means that there must be a consideration of the individual's unique construction of the events and the distress being experienced separate from the construction of the situation by significant adults. It has been empirically shown that adolescent perceptions of their levels of distress such as in the case of depression can differ from that of their parents (Berg-Nielsen, Vika, & Dahl, 2003).

Related to the importance of understanding how a child or young person experiences distress is the debate about what are the elements of interventions that actually bring about change during psychotherapy. Described as the 'common factors' debate (Parloff, 1986) this controversial debate has been based on the empirical findings that in many areas the particular form of theoretically driven intervention used to care for a person in psychotherapy may account for only a small proportion of positive outcomes, comparable in fact to the influence of what may be described as a placebo effect or a hope or expectancy effect. It is suggested that of much greater significance are extratherapeutic factors, that is, the life context of the person, and the ability of the psychotherapist to work with these, as well as the importance of the relationship and therapeutic alliance built between client and therapist (Hubble, Duncan, & Miller, 1999).

The importance of the therapeutic alliance has been emphasised in many studies in terms of bringing about change (Martin, Garske, & Davis, 2000), especially among children and young people (Geldard & Geldard, 2002). In recognising the importance of this alliance, the role of the therapist as person must then be acknowledged. The therapist as person becomes as important to the process of therapy as his or her abilities as a technician of a particular set of theoretically derived intervention strategies. Studies have found that personal qualities of the therapist, such as personality characteristics (Ackerman & Hilsenroth, 2001), ability to empathise (Gladstein, 1983), ability to generate hypotheses (Morran, Kurpius, Brack, & Rozecki, 1994), humour (Johnston,1990), purpose and values (Kelly, 1990), and attitude to clients can affect outcomes. Contrary to what may have been anticipated, as we further understand the mind objectively, the importance of these less easily defined, sometimes more intuitive abilities of the therapist to 'connect' with the client are being further reinforced. Siegel (1999) and Cozolino (2002) argue that the process of psychotherapy involves the ability of the therapist to engage and work with both the left side of the brain housing language, and the right side of the brain holding more of the accompanying emotions and perceptions. This is consistent with the skills development in teaching counselling that encourages both the ability to reflect the content of people's speech and the underlying feelings and unconscious inconsistencies (Ivey & Ivey, 2003). Siegel and

Hartzell (2003) further argue that understanding of the important concept of attachment to the wellbeing of a child and of that child later as an adult is to be found in the knowledge of this coexistence of these processes in both hemispheres of the brain that interpret and define events in the life of the child.

So literature is suggesting that we need to take greater note of the qualities of the people offering care to children and adolescents rather than just considering the evidence for the techniques that they employ to alleviate a particular problem. In other words, it may be less what is done than who does it and how it is done that is important. For many teachers and those working with children and young people, this makes intuitive sense to the work they have often been doing within their daily interactions. It may also shed some light on findings in the area of resilience literature that a positive relationship with at least one adult can act as a protective factor in terms of enhancing resilience in children and adolescents (Henry, 1999). It may also suggest that in training professionals to work with children and young people we must place greater emphasis on the development of the person and their personal skills of interaction than currently occurs in many tertiary training programs.

However, in pursuing the evidence base for interventions, there is limited research into the role of the therapist offering a technique, interactions between therapist and techniques and between client and techniques. For example, in terms of interaction of therapist and theory, Fear and Woolfe (1999) found that counsellor effectiveness was affected by the congruence between personal philosophy and theoretical orientation. Process outcome research and patient-focused research (Howard, Moras, Brill, Martinovitch, & Lutz, 1996) seek to consider cumulative effects during intervention as opposed to simply the summative effects considered in most intervention methodologies (Hawkins & Mathews, 1999; Miller, Duncan, Johnson, & Hubble, 2000). In addition, the increasing use of qualitative procedures to understand the processes in intervention will shed more light on how an intervention works than simply validating its effects and assuming the processes have occurred as proposed by the theory from which they were derived (Berg, 1998).

In other words, having good intentions and warm feelings toward one's charges does not necessarily lead to good outcomes. What is it about the way in which a particular therapist or teacher or health professional implements an intervention that makes it effective or ineffective even when the intervention is detailed and supposedly offered consistently across settings? What is it that effective therapists, parents, foster carers, youth workers and teachers are able to communicate to their charges that assists in producing positive outcomes? Again there are debates in the literature but also some convergence of sorts. There appear to be particular messages of self-efficacy, connectedness, belonging and enhanced sense of self and others that permeate many programs of resilience among children and young people (Grotberg, 1995; Murray, 2004). This recognition has led to whole school programs of mental health intervention based on core principles. For example, the Mind Matters (2000) and Gatehouse programs (Patton et al., 2000) used extensively in Australia have underlying messages of security, communication, connectedness and positive regard that they seek to incorporate in a variety of ways across the whole school setting. This idea of enhancing positive messages and reframing negative internal messages is consistent with many psychological theories. Personal construct theory with its techniques of narrative therapy (Strong & Pare, 2004) seeks to alter

negative entrenched internal constructs by the renarrating of stories to a different outcome. Meaning-making literature (Neimeyer, 2000) argues that people adjust to adversity by being able to find meaning in events or outcomes of those events. In a similar vein, the increasing interest in the areas of hope (Lester, 1995; Raleigh & Boehm, 1994) and posttraumatic growth (Joseph, 2004) takes the emphasis in even extreme areas of distress towards a recognition of the value of positive outcomes and processes rather than deficits alone. The increased interest in the area of positive psychology has led to the study of concepts such as hope, wisdom, creativity, future mindedness, courage, spirituality, responsibility and perseverance (Seligman & Csikszentmihalyi, 2000). The literature is even recognising that there is a need for both the good and the bad in development and that a mentally well person is also not one whose sole concentration is on the inner personal sense of satisfaction but who is also other-centered (Argyle, 2001). In fact, there is some suggestion that it is not necessary to have characteristics such as high self-esteem to experience positive mental wellbeing; that circumstances, practices and goals are also important (Diener, Suh, Lucas, & Smith, 1999; Lyubomirsky, Sheldon, & Schkade, 2005). The concepts of accepting both the good and bad as part of life and being able to think beyond oneself often sits more comfortably with many of those who work with children and young people and have objected to an emphasis on deficits, on preoccupation with individual happiness and self-esteem and an expectation that one must 'feel good' to be mentally well. It is even more controversial to suggest that it is all actually as simple as the ancient understandings and that it is about the word 'love' not the limited modern western concept of romantic love alone but a selfless and spiritual love, agape love. Patterson (1974) argues that:

> When one brings together the various aspects of the facilitative conditions — empathy, warmth, respect, concern, valuing and prizing, openness, honesty, genuineness, transparency, intimacy, self-disclosure, confrontation — it becomes apparent that they constitute love in the highest sense or agape. ...We already have in essence, the answer — the answer that has been reached through thousands of years of human experience and recognised by the great philosophers of various times and cultures (pp. 89–90).

However, before we start inappropriately discarding the value of training and clinical techniques we need to be aware that there is a great deal of evidence supporting the value of clinical skills and particular techniques in mental health problems (Roth & Fonagy, 2005). There is also evidence to support the value of an ability to 'fit' the correct intervention to the needs and characteristics of the individual (Groth-Marnat, Roberts, & Beutler, 2001), and working with the client's understanding of the problem and their perceptions of how change will be brought about (Duncan & Miller, 2000). This is a place where the contextual and medical models perhaps converge and complement each other. Is there really a need for conflict between these two positions?

The Need for Integration

The competition for influence between the medical and contextual models has seen major debates concerning where the limited funds available should be spent in providing for the mental health needs of children and young people. This debate occurs within the reality that there are never likely to be sufficient funds to meet increasing

needs, and hence priorities have to be set. National policy has tried to grapple with this issue (Raphael, 2000). The question arises as to whether funds should be expended primarily on the provision of relatively expensive mental health services with strong evidence-based treatments for a relatively small number of children and young people with diagnosed disorders, or whether a significant proportion of the funding should be spent in the area of prevention of disorder — where it is more difficult to determine best practice due to a lack of longitudinal studies, inadequacy of valid measures, and problems of confounding variables in naturalistic settings (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004; Davis, 2002). The answer to the dilemma is already recognised as not 'either/or' but 'and' and 'both'. In weighing up the evidence on all sides of the argument, the World Health report *Mental Health: New Understanding, New Hope* (WHO, 2001) made 10 recommendations for effective solutions to the increasing burden of mental illness on the global community. These recommendations included both prevention and promotion approaches as well as the enhancement of existing traditional clinical approaches to mental illness. This report recommended treatment in primary care; availability of psychotrophic drugs; community care and involvement; public education; consumer and family participation; national policies, programs and legislation; the development of human resources; intersectoral cooperation; monitoring of community mental health; and further research. Therefore, according to the WHO, providing a comprehensive approach to the care of mental health problems will necessarily require an integration of both medical and contextual models (WHO, 2001). Mzarek and Haggarty (1994) suggested such an integrated approach in considering the spectrum of mental health promotion across all levels of intervention. Approaches to care will need to range from preventative approaches (universal, selective, indicated) to rehabilitation. Not only will each area have to be strengthened within and of itself, but different approaches and different disciplines and sectors will need to be integrated. This includes the area of education. In addition, this integration needs to occur in all areas including rural and remote areas and among marginalised populations. These areas and groups are least likely to have ready access to specialised mental health services and hence to rely on professionals in other sectors with some training in the area. Among children and young people, the responsibility in more isolated areas largely falls to teachers. Such an integrated approach will also require the active involvement of consumers and the broader community. The National Mental Health Plan 2003–2008 (Australian Health Ministers, 2003) recognises the need for integration and proposes:

> a population health framework that takes into account the complex influences on mental health, encourages a holistic approach to improving mental health and well-being, and develops evidence based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention (p. 4).

The competition between models too is heightened as it is often played out in battles between competing disciplines and government departments. Traditional mental health services are often organised on a medical model that is hierarchical in nature and structure, recognises the preeminence of medically oriented disciplines such as psychiatry and psychology, is linked to hospitals and/or specialised mental health facilities, and is funded usually on a continuing basis within the health budget. In contrast, advocates for an increasing emphasis on the contextual model are

often those from backgrounds of the social sciences, community welfare, education and religion. They are less able to set up a hierarchical structure, are multidisciplinary, multisectoral and multisite in nature, and are funded often only on a limited project basis. Their recognition of a much broader definition of mental health than simply the absence of mental disorder can also mean that their measurable outcomes are often greater in number, less specific and less easily measurable over short time periods (DeNeve & Cooper, 1998).

With schools being places where all children and young people are to be found, any population-based approach to mental health necessarily involves guidance officers, school counsellors, teachers and the whole school community. Unfortunately, school communities are often left to provide mental health support without training in the area. Many are left to rely on their own commonsense approaches to mental health while trying to do their primary job of educating in the face of limited resources, large class sizes and the practical effects of teaching children who are showing behavioral signs of mental distress. Many teachers also challenge as a matter of commonsense the idea that all distress or even unhappiness is something that must be 'cured' or 'treated'. While the psychological community itself struggles with its own debate about methods and models within an environment of limited funding and political maneuving, teachers and children and young people may be left confused for years to come, continuing to rely on their commonsense.

Some Guidelines

So what may we tell teachers and others who care for the mental health of children and young people in the interim while the psychological community attempts to come to grips with the debates that rage about appropriate care? Simply, we can tell them that:

1. While nearly all young people will experience circumstances during their lives that distress them, only a minority will experience long-term problems. The majority will respond positively to simple supportive interactions and patience. Their life experience will shape them but need not defeat them.

2. Treat all distress in a respectful manner as no matter how we perceive its severity, the circumstances and the inner turmoil certainly matters to that individual child or young person. Your attitude to the problem may enhance or destroy any alliance you may have with the child or young person that could be useful in overcoming the problem.
3. Having a positive attitude to dealing with the problems of children and young people does not mean denying the importance of problems. It means believing in their ability to deal with the problem and using your knowledge to help them find the solution that has meaning for them within their context.
4. Often the child or young person, and his or her peers and family will be aware that a problem has become serious. Listen to what they vocalise, but also be alert for nonverbal information. Many of the most accurate

perceptions about mental state will not be made in verbal or conscious ways. Often it will be a teacher's intuition based on a continuing relationship with the child or young person that proves most accurate. Don't deny intuition even if you feel that you may overreacting, for there is strong evidence of its value (Hogarth, 2005).

5. Be alert to and aware of warning signs such as a sense of hopelessness or powerlessness, major and/or continuing changes in usual behaviour, and behaviour that is consistently extreme compared with that you see around you among the other children and young people with whom you interact daily. But make your own objective judgments. Don't be influenced by the impressions of others who may have a biased impression of the child or young person or by a label given externally in less than ideal conditions.
6. Make strong connections with the local mental health support services and invite them to be part of your school community before problems arise. Allow students to build trust with these other sectors before they may need to use them. Never be ashamed to admit an issue is out of your realm of expertise and collaboratively work with the child or young person to find the most effective means of support. However, make sure the message students receive is that referral is about valuing them and doing what matters for them, rather than wanting to shift the 'problem' to someone else.
7. Create a climate in your school that helps students feel safe both physically and emotionally, values people, and values a willingness to face a challenge yet acknowledges that there are times when it is acceptable to feel overwhelmed for a time. Learn to just 'sit' sometimes with students as they regain their strength and clear their thinking without feeling that they have to 'fix' the problem immediately.
8. Hear the whole story including the personal perspective of the child or young person. Often the problem as presented by him or her or others is not the most accurate source of information for determining the most effective intervention. You may need to earn a child or young person's respect by dealing sensitively with the presenting problem before the real issue is offered to you by him or her.
9. Help students to learn to accept the weaknesses of others and that there are many different ways to cope with a situation, even if these are unlike their own. Learn this yourself as a teacher or counsellor.
10. Take every opportunity, and actively seek more opportunities to be offered to you, to gain knowledge of mental health issues among children and young people.
11. Never forget that mental health lessons are not separate in the curriculum but integral to every lesson you teach. Be sure of the messages you want your students to gain about their mental health from your everyday encounters with them. Literature shows that resilience is enhanced not

only in specific programs but also in the daily hassles and encounters of life and the ordinary development that stems from this (Masten, 2001).

12. Never devalue the importance of your humanity and human concern to your students or clients. Training in mental health is important to children and young people but it will never replace the fact you care about them and the valleys and hilltops of their journey as a person.

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